STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ANDREW JACKSON BUILDING, 15TH FLOOR
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

TO: **Provider and Independent Support Coordination Agencies**

FROM: **Stephen H. Norris, Deputy Commissioner**

DATE: **January 9, 2008**

SUBJECT: **Cost Review Process**

As all of you know we are engaged in a considerable cost containment initiative that was implemented this past October. These beginning efforts have been unable to stem the spiraling cost of services for the statewide HCBS Waiver. Consequently, I am now soliciting your assistance with the efforts to keep DMRS expenditures in line with the approved budget for FY 2007-2008.

In October, I asked that Regional Office staff begin the process of reviewing all existing Cost Plans to assure that each person supported is receiving services in the most cost effective way possible. To aid in this process each region has developed a Review Committee consisting of a variety of specialties (Nursing, Therapies, Behavior, etc.) that can facilitate discussion about the cost effectiveness of services in their area. This review process is now underway and is estimated to be completed during March 2008. As Regional Office staff review cost plans they will be looking for efficiencies that could provide services at a lower cost. These identified efficiencies will be communicated to the agency providing the service and to the person's ISC for review and consideration of how services might be able to be provided in more cost effective ways. It is expected that provider agencies, ISCs and COSs will work together to determine if the services needed by the person can be met at a lower cost.

In addition, I am asking that provider agencies develop internal processes that will eliminate waste, assess the cost effectiveness of service provision and, at the same time, remain attentive to the needs of the people supported.

Finally, please accept my sincere appreciation for your efforts to ensure that needed supports and services are provided in the most cost effective manner possible for all Tennesseans with developmental and intellectual disabilities.

SHN: bsd

Cc: Dave Goetz, Commissioner of Finance and Administration
Darin Gordon, Deputy Commissioner, Bureau of TennCare
DMRS Assistant Commissioners
DMRS Regional Directors
DMRS Central Office Directors

Regional Office Individual Support Plan Review Protocol

January 9, 2008

I. Scope and Purpose

Regional Office Plans Review staff and other Regional Office staff as assigned, including clinical staff as needed, will conduct individualized reviews of 100% of Individual Support Plans (ISPs) and approved services between December 20, 2007 and March 1, 2008. Plans reviews will focus on ensuring that DMRS service recipients enrolled in the "Statewide" Home and Community Based Services (HCBS) 1915(c) waiver program are receiving the appropriate type and amount of services to meet identified individual needs in the most cost-effective manner in order to prevent institutionalization.

II. Development of Plans Review Protocols

The DMRS Policy Unit will develop service review protocols which specify medical necessity as well as other coverage criteria for each waiver service that will guide staff in conducting individualized reviews of ISPs in a consistent manner across regions. Protocols will be developed for clinical services initially, then for residential and day services, and then for the remainder of waiver services. Service review protocols will be submitted to TennCare for approval. Initial protocols will be implemented in mid-December with remaining protocols completed in mid-January.

III. Plans Reviews

A. Plans reviews will focus on determining if appropriate service rates are being paid to service providers. Any change in service rates that results in an adverse action to a service recipient (including any reduction in the frequency, scope, intensity, or duration of a waiver service, e.g., when the rate that has been paid is tied to a level or intensity of service that will be reduced when the rate is reduced) shall proceed in accordance with all applicable Grier requirements. This includes requirements regarding medical necessity determinations when the affected service is covered under the 1915(c) waiver program, but it is determined that a different type or level of service would more appropriately and/or cost-effectively meet the service recipient's needs.

B. Additionally, plans reviewers will determine if services have been approved through the waiver that should, pursuant to federal regulation, be provided via a TennCare Managed Care Organization (MCO) or Behavioral Health Organization (BHO), since services provided under a 1915(c) waiver program may not supplant medically necessary services covered under the Medicaid State Plan (or 1115 demonstration waiver). Particular focus will be given to services provided to service recipients under the age of 21 that are covered when medically necessary under the TennCare Program. If the scope of the service provided under the 1915(c) waiver is the same as that provided under the TennCare program, all medically necessary services should be provided by the TennCare MCO or BHO and not through the 1915(c) waiver program.

C. Reviews will be completed utilizing plans review protocols as they are implemented. Plans reviewers will conduct an individualized review of the appropriateness of the types and amounts of services being provided in accordance with service review protocols.

D. New ISPs and ISPs submitted for annual review or amendment between December 20, 2007 and March 1, 2008 will be processed in accordance with

established procedures; however, service review protocols, as they are implemented, will be used to adjudicate all service requests. Regarding requests for new services (those included in an initial ISP, annual ISP renewal, or ISP amendment) that are denied or partially approved in accordance with service review protocols, the usual process for providing Grier notice and appeals must be followed.

E. When services are identified that are currently being reimbursed under the waiver that are covered when medically necessary under the TennCare program, the process for transitioning service provision to the MCO or BHO will begin. DMRS Central and Regional Office Staff will assist in coordinating transitions and appeals. Central Office Staff, including the Assistant Commissioner of Policy, Planning, and Consumer Services, who serves as the DMRS liaison to TennCare (Joanna Damons), the Director of Appeals (Jon Hamrick), the Medical Director for Policy and Governmental Relations (Dr. Moore), the Assistant Commissioner of Community Services (Debbie Payne), and other DMRS Operations staff will assist upon the request of Regional Director. Dr. Moore, Joanna Damons, and Jon Hamrick will seek assistance from the TennCare Developmental Disability Services staff and TennCare Solutions Unit staff as needed to coordinate transitions and appeals. HCBS 1915(c) waiver services will continue until the MCO has reviewed a request for the service(s) and rendered a decision. The transition process will proceed as follows:

1. The Individual Support Coordinator (ISC) will be expected to ask the physician to submit a request for the service to the service recipient's Managed Care Organization or Behavioral Health Organization, with assistance from the provider if needed, no later than ten (10) days following a directive from DMRS to begin the transition process. Regional Office staff will assist the ISC and/or provider if unusual difficulty is encountered in obtaining physician's orders or submitting the request in a timely manner. The ISC will be responsible for monitoring whether or not the physician requested the service through the Managed Care Organization or Behavioral Health Organization.

2. If the MCO or BHO determines that the services are medically necessary, DMRS will monitor the progress of the transition and continue to provide reimbursement for waiver services until a date has been identified for transition to the MCO or BHO. Notice of termination of waiver services will be issued on the identified date of transition, in accordance with applicable Grier requirements.

3. If the initial MCO decision involves the denial of medical necessity of nursing services for children under age 21, DMRS Regional Office staff will complete and mail a Grier notice informing the service recipient and legal representative, as appropriate, that waiver services will be terminated in (ten) 10 calendar days from the date the notice is received (presumed to be five (5) days after the date the notice is issued). The notice will be copied to the service recipient's ISC and affected service providers.

4. If the initial MCO or BHO decision involves the denial of medical necessity of other clinical services (e.g., nutrition, therapy, or behavioral services), DMRS will reconsider whether the service being denied by the MCO or BHO is appropriate for coverage under the waiver, based on approved waiver service definitions and service review protocols containing medical necessity criteria.

a. If services are appropriate for coverage under the waiver, the services will be authorized to continue following established service authorization procedures.

b. If services are not appropriate for coverage under the waiver, DMRS will issue notice of termination in accordance with applicable Grier requirements when appeal rights have been exhausted, including final disposition of any MCO/BHO appeals that are pending.

5. The legal basis for denial or termination of waiver services that are covered when medically necessary under the TennCare program is that federal regulations do not permit a waiver service to supplant covered benefits available under a State's Medicaid program [42 CFR, Section 440.180; State Medicaid Manual, Section 4442.1]. This language will be included in the notice.

6. Allowing five (5) days for receipt of the notice, the service recipient will have thirty (30) calendar days from the date the notice is received to file a timely appeal regarding the termination of waiver services in accordance with Grier. Should an appeal be received within 10 days from the date the notice is received (or 15 days from date of notice), the service recipient may request continuation of waiver services pending resolution of the appeal. If no appeal is received prior to the 15th calendar day following issuance of notice, the service will be terminated on the 16th calendar day from the date of the notice.

F. When plans reviews identify that the appropriate type and/or amount of services are not being provided, or that the service recipient's needs can be met in a more cost-effective manner, plans reviewers will produce written recommendations for changes in the ISP. Written recommendations will be forwarded to the service recipient's ISC and providers affected by the recommended change via fax or e-mail. The ISC will be responsible for advising the service recipient if DMRS has recommended change(s) in the ISP and explaining that they will receive a notice and opportunity to appeal if the recommended change results in denial, termination, reduction, or suspension of waiver services (including the frequency, intensity, scope and duration of such services).

G. Upon receipt of a recommendation for change in the ISP, the service recipient or legal representative (as applicable), the ISC acting on behalf of the service recipient, or the service provider may agree or disagree with the proposed recommendation.

1. If the service recipient and legal representative (as applicable), ISC, and provider agree with the proposed change(s) to the ISP, the ISC will submit an amendment to the ISP, specifying such change, within 10 calendar days. DMRS will issue a Grier notice when the ISP amendment involves a termination, suspension, or reduction of service. The Grier notice will advise the service recipient of the adverse action to be taken, the reason for the adverse action, and applicable appeal rights.

a. The service recipient will have 35 calendar days (including five days mail time) from the date of the notice to appeal an adverse action affecting any service they are currently receiving. However, requests for continuation of the service(s) will not be

granted unless the appeal is received within 15 calendar days from the date of the notice (including five days mail time).

b. If an appeal is received that makes timely request for continuation of services, DMRS will continue to provide reimbursement for the waiver service until the appeal is resolved. The adverse action will not be taken unless a directive is received from the TennCare Solutions Unit or a final order is received following an administrative hearing that indicates that DMRS may proceed with the adverse action.

c. If an appeal is received within 15 days of the date of the notice that does not request continuation of services, the adverse action will be taken on the 16th calendar day. Reimbursement for the service will not be available until and unless a directive is received from the TennCare Solutions Unit or a final administrative order is received that requires DMRS to reinstate the service.

d. If an appeal is received between the 16th and 35th calendar day of the date of notice, the adverse action will have been taken and continuation of the service will not be granted. Reimbursement for the service will not be available until and unless a directive is received from the TennCare Solutions Unit or a final administrative order is received that requires DMRS to reinstate the service.

2. If the service recipient and legal representative (as applicable), ISC, or affected provider(s) disagree with the proposed change, additional information may be submitted to show that the proposed change will not meet the service recipient's needs and request that current services continue. Alternative changes that would meet the service recipients needs in a cost-effective manner may be suggested. Additional information must be submitted to the DMRS Regional Office in writing by the ISC (acting on behalf of the service recipient) or service provider within ten (10) calendar days of receipt of DMRS recommendations. Service providers submitting additional information must copy all information submitted to the ISC. ISCs must forward to the affected provider(s) any additional information submitted that was not obtained from the provider.

3. Upon receipt of additional information, a Regional Office Team comprised of plans review staff and clinical staff with expertise in the service(s) under consideration for change will review the information and take one of the following actions:

a. Notify the ISC and provider that the additional information provided justified continuation of the service as approved in the current ISP and that further changes will not be pursued at this time.

b. Notify the ISC and provider that alternative suggestions are appropriate, with required ISP changes due within ten (10) days. Any alternative suggestions and ISP changes that result in denial, suspension, reduction or termination of services will trigger a ten (10) day Grier notice (allowing five (5) days mail

time for receipt of such notice) that advises the service recipient of the adverse action and explains appeal rights.

c. Provide notice in accordance with Grier that the service(s) under consideration will be terminated or reduced in ten (10) calendar days following receipt of such notice. Allowing five days for mail time, the service recipient or the service recipient or another party acting on behalf of the service recipient may appeal within 35 days after the date of the notice.

   i. Continuation of benefits shall be provided as specified in Phase I, D. above. If continuation of benefits is authorized, the service will be terminated, suspended, or reduced only upon receipt of a TennCare directive or final order following a fair hearing or withdrawal of the appeal.

   ii. If no appeal is received, the service will be terminated on the 16th day after the date of the notice.

Service Provider Actions to Promote Cost-Effectiveness in Service Delivery

The DMRS service delivery system is a partnership between the service recipient, the providers of services, and DMRS. Consequently, service recipients as well as ISCs and other service providers share in the responsibility of ensuring that services are provided to meet individual service recipients' needs in the most cost-efficient manner. DMRS recommends that service providers take the following actions to demonstrate attention to cost-effectiveness in the delivery of services.

A. Service providers will be expected to participate in internal reviews of all ISPs for each service recipient supported to determine how to meet identified needs in the most appropriate and cost-efficient manner. Any needed changes to the ISP that result from these reviews will be communicated to and facilitated by the ISC. The service recipient and the service recipient's legal representative, as applicable, will be advised of any proposed ISP changes by the ISC. Suggested focus areas for review include, but are not limited to the following:

1. Ensuring that supported living residences support a minimum of two (2) people with the exception of service recipients for whom a housemate would result in imminent danger to others or those who chose a cost-effective alternative for single person placement such as companion model or family model residential services;

2. Ensuring that community-based and supported employment day services are provided in a manner that promotes the most effective use of staff;

3. Ensuring that the number of service units currently approved and requested in the future are necessary to meet individual needs;

4. Ensuring that current and future residential and day rates are paid at the appropriate rate level;

5. Ensuring that any Special Needs Adjustments currently approved and requested in the future are appropriate;

6. Ensuring that any overnight awake staff currently available or considered in the future are needed; and

7. Assisting in transitioning clinical services to the MCO or BHO when DMRS determines that the benefit is covered when medically necessary under the TennCare program, as well as, ensuring that in the future, services covered under the TennCare program are requested from the MCO or BHO prior to submitting a request for waiver services.

B. Providers are expected to complete cost–effectiveness reviews and submit any suggestions for achieving more cost-effective service delivery for specific individuals to the Regional Office Plans Review Unit by January 30, 2008. Suggestions for systemic changes to achieve more cost-effective service delivery should be submitted to the Regional Director by February 29, 2008.

C. Provider suggestions pertaining to specific individuals will be reviewed by a Regional Office review team comprised of plans review staff, clinical staff as needed, and other

administrative/management staff. The Regional Office Teams will respond to provider suggestions in one of the following ways:

1. If the DMRS Regional Office Review Team agrees with the suggestion and the suggestion involves a service denial, termination, reduction, or suspension, DMRS will issue a notice and initiate transitions (as described in Section III. E. above) or appeals processes in accordance with Grier.

2. If the DMRS Regional Office Review Team disagrees with a suggestion to deny, suspend, reduce, or terminate a service, DMRS will provide a written response to the provider who submitted the recommendation explaining why DMRS will not take action based on the suggestion.

3. If the suggestion does not involve a service denial, termination, reduction, or suspension, a written response describing DMRS' intended action in response to the suggestion submitted will be forwarded to the provider.